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1.1 INTRODUCTION

This manual describes the methodology (guidelines) to be used by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, to establish per diem rates for agencies providing care to residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR) participating in the Title XIX Medicaid program. These guidelines have been developed by the New Jersey Department of Human Services Office of Finance and the Division of Medical Assistance and Health Services, hereafter referred to as "the Department," in accordance with applicable Federal regulations as set forth in the Code of Federal Regulations.

The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government. The Code is divided into 50 titles which represent broad areas subject to Federal regulation. Each title is divided into chapters which are further subdivided into parts covering specific regulatory areas. The rules and regulations governing the ICF/MR program are contained in Title 42-Public Health (Part 400 to 420). References to these Federal regulations will be made throughout this manual.

Inquiries concerning technical aspects of the Code should be addressed to the Director, Office of the Federal Register, National Archives and Records Administration, Washington, D.C., 20402. Sales are handled exclusively by the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402.

The Department believes that the application of these guidelines will generally produce equitable rates for reimbursement to the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) for costs incurred in providing routine resident care. The Department recognizes, however, that no set of guidelines can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities can be in the form of rates that are unduly low or rates that are unduly high.

Accordingly, in a case where an ICF/MR provider believes that, owing to an unusual situation, the application of these guidelines results in an inequity, the Department is prepared to review the particular circumstances with the ICF/MR provider through the appeals process described in this Section. Appeals on the grounds of inequities should be limited to circumstances peculiar to the ICF/MR affected. They should not address the broader aspects of the guidelines themselves.

The Department reserves the right to question and exclude from rates any unreasonable costs.

Reimbursement rates established by the Department will be subject to on-site verification of costs and statistics reported by ICF's/MR.

The ICF/MR Reimbursement formula has been developed to meet the following overall goals:

- to provide sufficient reimbursement to assure adequate levels of patient care; and
- to comply with Federal requirements for a reasonable cost-related rate.

1.2 DETERMINATION OF ICF/MR COST-RELATED RATES

The ICF/MR rate setting process is a retrospective system as opposed to a prospective system. Interim per diem rates are initially established to reflect the estimated costs for a future reporting period (provider's fiscal year). When the actual costs are reported for the period, a final rate is established and retroactive adjustments (upward or downward) are made to the provider's reimbursement to reflect the actual allowable costs incurred.

Allowable Costs for Reimbursement

Allowable costs are determined in accordance with Medicare principles of reimbursement as set forth in 42 CFR Part 413. However, certain items of cost considered allowable by the Federal Government in administering the Medicare Program must be excluded when determining cost allowable and allocable to the ICF/MR program. Examples of these cost items are bad debts attributable to the deductibles and coinsurance amounts peculiar to the Medicare Program and Charity and Courtesy allowances.

The Federal Government has published a Medicare Provider Reimbursement Manual referred to as HIM-15. This manual contains informational and procedural material on various aspects of the determination of cost and will assist providers in preparing cost reports. For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.

As an additional aid to the provider in preparing the ICF/MR cost reports, Section 3 of the ICF/MR Provider Manual contains "General Principles for Determining Costs." These cost principles reflect generally accepted accounting principles and should be used by the provider only as a guide. The Medicare principles of reimbursement are the governing regulations applicable to the ICF/MR program and must be used instead of the "General Principles for Determining Costs," if any differences in the treatment of specific items of cost exist.

Under generally accepted accounting principles, or under the Medicare principles of reimbursement, there may be more than one method for handling a particular item of cost. In such cases the method elected by the provider must be approved in advance by the Department's Bureau of Rate Setting.

Throughout the Medicare principles of reimbursement, reference is made to an intermediary. For purposes of the State's ICF/MR program, any reference to the intermediary is the same as referring to the Department's Bureau of Rate Setting.

Establishment of the Interim Rate

Interim payment rates will be established by the Bureau of Rate Setting and may be related to the last year's per diem rate or to any other ready basis of approximating reasonable costs under the Medicare principles of reimbursement.

An interim rate can be established by one of several methods. One method is for the ICF/MR provider to prepare a cost report based on projected costs for the specific future reporting period (agency's fiscal year). This projected cost report should be provided on the standard cost report format prescribed by the Department of Human Services, Bureau of Rate Setting. The projected cost report should be submitted no later than three (3) months prior to the first day of the provider's fiscal year for which the rate will be used. The Bureau of Rate Setting will perform a desk analysis of the provider's proposed interim rate and establish a recommended interim rate based on the Medicare principles of reimbursement. This approach for establishing an interim rate is used for new ICF/MR providers in the program or for providers with changes in their total organizational activities and operations and/or changes to the ICF/MR program services.

A second method for establishing an interim per diem rate for the ICF/MR program is to base the rate on the provider's actual expenditures as reported on the annual cost report filed with the Bureau of Rate Setting. This annual cost report is the basis for establishing the provider's final per diem rate for a prior fiscal year. The provider's actual allowable expenditures may be adjusted to reflect the appropriate inflationary increments for major categories of costs. This method can only be used for providers already in the program (at least one completed fiscal year) and whose total organizational activities and operations do not significantly change.

The Bureau of Rate Setting will recommend the interim rate to the Director, Division of Medical Assistance and Health Services. The Director, Division of Medical Assistance and Health Services, will approve the rate and provide the appropriate reimbursement to the provider based on this approved interim ICF/MR per diem rate.

Interim per diem rates may be adjusted upward or downward during the fiscal year to reflect changes in levels of expenditures or changes in program services. Modifications to the initial interim rate may be based upon a request by the provider or a recommendation of the Bureau of Rate Setting.

Establishment of the Final Rate Pending Audit

The final ICF/MR per diem rate is established in two stages. The first stage involves establishing the final rate prior to an audit. The ICF/MR provider is required to submit an annual cost report to the Bureau of Rate Setting within 6 months after the close of its fiscal year. The Bureau of Rate Setting performs a desk analysis of the final cost report in accordance with the Medicare principles of reimbursement and establishes a recommended final rate pending audit. This recommended rate is furnished to the Director, Division of Medical Assistance and Health Services, who affects the necessary adjustment to the provider's reimbursement and the Federal claim for reimbursement. If an audit of this rate is not planned for a particular provider, the rate will represent the final settlement with the provider. An audit of the final rate will always be conducted for provider agencies whose provider agreement has been terminated.

Establishment of the Final Rate After Audit

The second stage involves the audit function. For those ICF/MR facilities that participate in the Medicare program, the audit performed by the provider's Medicare fiscal intermediary can be utilized to establish the final rate after audit. An audit of the provider's actual costs and statistical data may be conducted by the Department of Human Services, Office of Auditing, which has the audit responsibility for providers of ICF/MR services under the Medicaid program.

Audits will be conducted in accordance with applicable Federal audit requirements and generally accepted auditing standards. The audit will ensure that the ICF/MR provider is reporting costs in accordance with generally accepted accounting principles and the Medicare principles for reimbursement.

When an audit is conducted by the Office of Auditing, an audit report will be issued recommending to the Bureau of Rate Setting the final ICF/MR per diem rate. The audit report will disclose each element of cost as reported by the provider. For each element of cost, the report will show the auditor's recommended costs as follows:

	Recommended Costs Per Audit		
Allowable	Questioned	Unsupported	Expl. Notes

Each audit adjustment will be adequately detailed in the auditor's explanatory notes. The auditor will compute the recommended final rate and determine the total allowable ICF/MR costs by multiplying the recommended per diem rate by the total eligible ICF/MR resident days.

The Bureau of Rate Setting will review an audit report and utilize the audit recommendations as a tool for setting a final audited rate and final settlement with the provider agency. The Bureau of Rate Setting is responsible for preparing a Negotiation Memorandum disclosing the details of the final rate settlement with the provider agency. This Negotiation Memorandum must provide adequate justification for each element of cost which differs from that recommended by the audit report. The Office of Auditing will be furnished a copy of the Negotiation Memorandum applicable to audits performed by DHS or outside audit agencies. If the Audit Manager feels the settlement made by the Bureau of Rate Setting was inappropriate, he may request that the Director of Finance, Department of Human Services, and the Director, Division of Medical Assistance and Health Services, investigate the adequacy of the procedures, judgements and decisions made by the Bureau of Rate Setting. This review process is a Department internal control procedure to provide the additional assurances that actual allowable costs are properly accounted for.

The Bureau of Rate Setting will then recommend the final audited per diem rate to the Director, Division of Medical Assistance and Health Services, for his approval and final payment settlement with the ICF/MR provider.

Overpayments Due to Excessive Interim Rates

If, during the course of desk analysis or audit, it is determined that an overpayment exists, the amount of the overpayment is a debt owed to the State of New Jersey. The Bureau of Rate Setting will notify the Director, Division of Medical Assistance and Health Services of the amount of the overpayment.

There are generally two ways in which repayment can be made: (1) refund of the entire amount of the overpayment (2) reduction of the interim payments to recapture the overpayment within a twelve-month period.

Refund of the entire overpayment is always preferred. However, where such a refund would create a financial hardship for the provider, recapture of the overpayment through a reduction of the interim payments or a combination of the two methods is acceptable.

If the provider's agreement has been terminated, a final cost report must be submitted within 45 days after the effective date of the termination of the agreement. If an overpayment is determined during the course of desk analysis or audit, the provider will be notified of the overpayment. Refund of the overpayment will be required within 30 days of this notification.

If overpayments are not refunded, it will be necessary to take legal action to collect the overpayment. If such legal action becomes necessary, interest at the legal rate from the date of notification, will be assessed and collected as part of any judgement by the court.

1.3 REASONABLE COSTS

The desk analysis performed by the Bureau of Rate Setting for the purpose of establishing the interim or final rate will include appropriate tests to determine reasonable costs as defined in the Medicare principles of reimbursement. Where appropriate, the Bureau of Rate Setting may request that the Department's Division of Developmental Disabilities perform a program review of staffing ratios and certain non-salary items of the provider's submission to determine the reasonableness of the cost of program services, mainly to avoid excessive costs.

A reasonable cost shall mean those costs of an individual facility for items, goods and services, which when compared, will not exceed the costs of like items, goods and services of facilities comparable in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing the health care services.

ICF/MR providers are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. When it is determined that reported costs exceed those levels, and in the absence of proof that the situation was unavoidable, the excessive costs will not be reimbursed.

In determining reasonableness, all provider costs will be subject to the limitation which may be imposed by the Medicaid program. The Bureau of Rate Setting will inform the providers of the limitations enforced on a current basis and reflect these cost limitations into the rate setting process.

1.4 SUBMISSION OF COST REPORTS

The ICF/MR provider will be subject to a penalty reducing its total reimbursable costs if it fails to comply with any of the reporting requirements indicated below.

Reporting Requirements

1. Submission of a budgetary cost report no later than three (3) months prior to the start of the provider's fiscal year for the establishment of an interim rate (if requested in writing by the Bureau of Rate Setting).

2. Submission of interim actual cost reports no later than thirty (30) days after the end of the interim reporting period (if requested in writing by the Bureau of Rate Setting).

3. Submission of the annual cost report within six months after the end of the provider's reporting period (fiscal year).

4. For provider agencies, whose provider agreement has been terminated, submission of the final cost report is required within 45 days after the effective date of termination date of the agreement.

Late Submission of Cost Reports

To ensure the timely receipt of cost reports, the Bureau of Rate Setting will send a reminder letter to the provider thirty (30) days prior to the date on which the cost report is due.

If the provider has not filed its cost report by the first day after the due date of the cost report (including extensions) the Bureau of Rate Setting will send a first demand letter to the provider. The letter will inform the provider that if the cost report is not received within thirty (30) days of the date of the first demand letter, the Bureau of Rate Setting will recommend that the Director, Division of Medical Assistance and Health Services reduce the provider's interim per diem rate by 20%.

If the Bureau of Rate Setting does not receive the cost report or a response to the first demand letter within thirty (30) days, a recommendation will be made to reduce the provider's interim per diem rate, and a second demand letter will be sent to the provider. The second demand letter will inform the provider of the recommendation. The letter will also inform the provider that if the cost report or a response is not received within thirty (30) days of the date of the second demand letter, the Bureau of Rate Setting will recommend that the Director, Division of Medical Assistance and Health Services suspend all payments to the provider.

If the provider does not respond or submit a cost report by the thirtieth (30th) day from the date of the second demand letter, a recommendation will be made to suspend payments and declare all prior payments to the provider to be overpayments. (See Overpayments Due to Excessive Interim Rates.)

In the case of a terminated provider agreement, the Bureau of Rate Setting will inform the terminated provider, by letter, that the final cost report is due within forty-five (45) days after the effective date of the termination date. If the provider does not respond or submit a cost report within forty-five (45) days after the effective date of the termination date, the Bureau of Rate Setting will recommend that the Director, Division of Medical Assistance and Health Services, declare an overpayment has been made to the provider. (See Overpayments Due to Excessive Interim Rates.)

Extensions

The provider may request in writing to the Bureau of Rate Setting, one 30-day extension for any of the reporting requirements listed above. The provider must provide an appropriate justification for the requested extension of time. The written request must be received by the Bureau of Rate Setting prior to the required filing date. The Bureau of Rate Setting may accept or reject the requested extension based on the written justification furnished by the provider.